Supreme Court, U.S.
FILED
JAN 16 1996
OFFICE OF THE CLERK

NO. 95-1194

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

CHERYL M. PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Nebraska corporation,

Respondent.

APPEAL FROM A JUDGMENT OF THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT IN AND FOR BROWARD COUNTY, FLORIDA, IN THE DISTRICT COURT OF APPEAL OF FLORIDA, FOURTH DISTRICT

PETITION FOR WRIT OF CERTIORARI

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28 pp

QUESTIONS PRESENTED FOR REVIEW

I. WHERE THE STANDARD OF REVIEW TO BE APPLIED RESPECTING AN ACTION CREATED AND GOVERNED BY A FEDERAL STATUTE HAS BEEN DETERMINED BY THE UNITED STATES SUPREME COURT, MAY A STATE COURT PROPERLY APPLY A CONTRARY STANDARD OF REVIEW.

II. MAY AN APPELLATE COURT ASSUME THAT THE WRONG STANDARD OF REVIEW WAS APPLIED IN THE LOWER COURT WHERE NO STANDARD WAS ARTICULATED IN THE JUDGMENT UNDER REVIEW.

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OPINIONS AND ORDERS

The Opinion of the District Court of Appeal of Florida, Fourth District is reported as United of Omaha v. Peloquin, 660 So.2d 1069 (Fla. 4th DCA 1995) Rehearing denied, October 17, 1995, and is contained in the Appendix at pages 1-7.

An Order denying a Motion for Rehearing/Motion for Rehearing En banc is reported as United of Omaha v. Peloquin, 660 So.2d 1069 (Fla. 4th DCA 1995) Rehearing denied, October 17, 1995, and is contained in the appendix at page 8. These are the only reported decisions.

An unreported Final Judgment from the Seventeenth Judicial Circuit in and for Broward County, Florida is contained in the Appendix at page 9-12.

CONCISE JURISDICTIONAL STATEMENT

The Opinion of the District Court of Appeal of Florida, Fourth District, upon which review is sought, is dated August 2, 1995. A request for Rehearing/Rehearing En banc was denied by Order dated October 17, 1995. The said Opinion and Order denying Rehearing/Rehearing En banc was rendered by the "state court of last resort" as contemplated by Sup. Ct. R. 13. This Petition was timely filed within 90 days of the date of the Order denying the Motion for Rehearing/Rehearing En Banc. Jurisdiction of this Court is invoked under 28 U.S.C. Section 1257(a).

STATUTES

The Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. Section 1001 et. seq., specifically 29 U.S.C. Section 1132(a)(1)(B).

> (a) Persons empowered to bring a civil action. A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

STATEMENT OF THE CASE

The United States Supreme Court in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103, L.Ed.2d 80 (1989), determined that whenever a benefit plan falling within the purview of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et. seq. (hereafter "ERISA"), gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a trial court is to review the administrator's denial of a claim for benefits under an 'arbitrary and capricious' standard.

The concerned ERISA Plan gave discretionary authority to UNITED to interpret the terms of the plan and to deny benefits as follows:

> AUTHORITY TO INTERPRET POLICY:
> By purchasing (this policy) or (these

> policies), the policyholder grants (United of Omaha Life Insurance Company) or (Mutual of Omaha Insurance Company) the discretion and the final authority to construe and interpret the (Policy) or (Policies). This means that (United) or (Mutual) has the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the (Policy) or (Policies) as interpreted by (United) or (Mutual). In making any decision, (United) or (Mutual) may rely on the accuracy and completeness of any information furnished by the policy holder or an insured person. (United) or (Mutual) interpretation of the (policy) or (policies) as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The issue of the standard to be applied by the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (the trial court) upon its review of the Plan administrator's denial

of benefits was not directly raised or addressed by either party. [1]

The question of the applicable standard of review (the federal question herewith concerned) was first raised by the appellee on the appeal before the District Court of Appeal of Florida, Fourth District. (See Appendix page 6). The court of appeal determined that there was:

> no indication that the trial court considered, or was asked to consider, the denial of th[e] claim on any basis other than by interpreting the policy and applying the stipulated facts...

and the appellate court reviewed the matter without reference to application of the standard of

---

[1] The only reference by either party respecting "standard of review" was with regard to review of the Plan wording and not review of the denial of benefits quoting Boland v. King County Medical Blue Shield, 798 Fed. Supp. 638, 646 (W.D. Wash., 1992) and was contained in Plaintiff's Motion for Summary Judgment.

review mandated by Firestone, supra. (See Opinion, last paragraph, in Appendix, page 6).

ARGUMENT

The Petition sub judice should be granted:

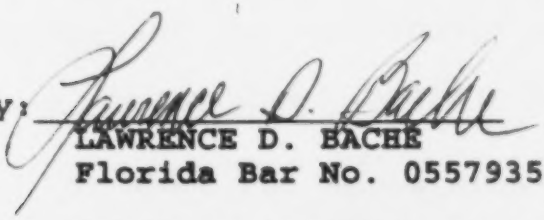
BECAUSE to countenance contempt, or even the appearance of contempt, by a state court for any pronouncement of the highest court in the land respecting administration of the law, would be to undermine and put in disarray the nation's entire system of justice. A fortiori where the pronouncement flouted was with respect to a federal statute. The District Court of Appeal of Florida, Fourth District, in the instant case not only disregarded the determination of this court as to the applicable standard of review, but went so far as to suggest that the issue was still open for resolution. (Appendix page 6).

BECAUSE any decision of a state court in de facto derogation of this Court's authority, if unrepudiated and unaddressed, undermines public confidence in the competence of the judiciary as a whole. The concerned opinion is manifestly such a decision.

BECAUSE The District Court of Appeal of Florida, Fourth District's failure to apply the maxim omnia praesumunter rite esse acta in the absence of a statement by the lower court as to the standard of review it was applying is in diminishment of the competence of that court and thus constitutes a threat to the common weal.

FOR THESE REASONS Certiorari should issue herein.

Respectfully submitted this 12 day of January, 1996

By: 
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served by U.S. Mail this 12 day of January, 1996 upon:

R. Fred Lewis, Esq.
KUVIN LEWIS RESTANI & STETTIN, P.A.
7325 S.W. 63rd Avenue
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Courtesy copy to:

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By: Lawrence D. Bache
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NO. _____

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

CHERYL M. PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE
INSURANCE COMPANY,
a Nebraska corporation,

Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

IN THE DISTRICT COURT OF APPEAL OF
THE STATE OF FLORIDA FOURTH DISTRICT,
JULY TERM 1995

UNITED OF OMAHA LIFE INSURANCE CO., a Nebraska corporation,

Appellant(s)

vs.

CHERYL M. PELOQUIN, et. al.,

Appellees(s)

CASE NO. 94-0163

L.T. CASE NO. 92-13834 09 BROWARD

Opinion filed August 2, 1995

Appeal from the Circuit Court for Broward County; Lawrence Korda, Judge

R. Fred lewis of Magill & Lewis, P.A., Miami, for appellant.

Lawrence D. Bache of Law Office of Lawrence D. Bache, Pembroke Pines, and Roy Taylor, Miami, for Appellee - Cheryl M. Peloquin

STONE, J.

We reverse a final judgment entered in favor of the insured, Peloquin, against the insurer, United of Omaha, for wrong-

fully denying her benefits for treatment of a medical condition, endometriosis of the colon. The insurer denied payment for the treatment, as not covered under the terms of its group policy, because the insured was receiving medical care for the condition at the time she applied for the policy. After denying cross motions for summary judgment, the court conducted a final hearing at which no evidence was presented by either side, both relying on the depositions and affidavits of record.

The policy contains a pre-existing conditions rider which defines a preexisting condition as:

> a condition for which treatment or services were [sic] received or prescribed drugs or medicines were taken within 180 days prior to the date the person was insured under this Master policy ...
>
> ***
>
> All related conditions shall be considered to be one injury or sickness.

In the "definitions" portion of the policy, the term "sickness" is defined as:

> a disease, disorder or condition (including complications of pregnancy) which requires treatment by a physician....

By her signature on the application, Peloquin agreed that she understood the following:

> This (policy/certificate) has a pre-existing condition limitation and if a physician has provided treatment or recommended treatment for any injury or illness or other condition within the six-month period prior to issuance of the (policy/certificate) for which I am applying, no coverage will be provided for that illness or injury or other condition until six months after the (policy/certificate) has been issued.

The depositions and affidavits reflect that the insured was being treated in June of 1990 for severe abdominal pain, the cause of which was, at the time, unknown. She was referred to a specialist and a colonoscopy was performed in August

leading to a September surgery and biopsy which revealed that the problem was an obstruction caused by the endometriosis. The medical testimony is unrefuted that the abdominal paid for which the insured was being treated prior to applying for the policy was caused by the endometriosis condition first diagnosed after the policy was in effect.

In Life General Security Ins. Co. v. Cook, 648 So.2d 237 (Fla. 4th DCA 1994), a case not available to the trial court, we recognized that a similar policy exclusion precluded coverage where the insured was being treated for a previously undiagnosed illness and the evidence was undisputed that the preexisting symptoms for which treatment was being sought were caused by the illness for which the insured was seeking coverage. We recognize that the policy at issue in Cook defined pre-exist-

ing conditions to include any conditions for which symptoms were evident. However, we do not consider this distinction to be significant, as the policy in the instant case included in its definition of pre-existing condition all conditions related to those for which treatment was previously sought.

The insured has failed to demonstrate that she is entitled to benefits under the policy. We understand the trial court's reluctance to deny coverage based on a condition as common as abdominal pain. However, the insured points to no evidence that the pain for which she was being treated might have been related to any condition other than that finally diagnosed, albeit after the coverage commenced. The unrefuted testimony is that the endometriosis condition was present at all relevant times and was the cause of

the pain for which she was receiving ongoing treatment and diagnosis at the time of her application.

The trial court apparently resolved this issue through a de novo review. Appellee asserts that since the group policy is governed by the Employee Retirement Income Security Act (ERISA Sec. 402-(b)(3), the issue should have been whether there was an abuse of discretion by the plan administrator; in this case the insurer. However, there is no indication that the trial court considered, or was asked to consider, the denial of this claim on any basis other than by interpreting the policy and applying the stipulated facts on the merits of the insured's claim. Therefore, we have reviewed the trial court decision on the basis presented to it, without deciding whether, in similar cases the coverage issue should be

resolved by finding whether the administrator's decision was arbitrary.

Therefore, the final judgment is reversed.

PARIENTE, J. and BROWN, LUCY, Associate Judge concur.

IN THE DISTRICT COURT OF APPEAL OF
THE STATE OF FLORIDA FOURTH DISTRICT,
P.O. BOX 3315, WEST PALM BEACH, FL 33402

UNITED OF OMAHA LIFE INSURANCE CO., etc.
Appellant(s)

CASE NO. 94-00163

vs.

CHERYL M. PELOQUIN, et. al.,
Appellees(s)

L.T. CASE NO. 92-13834 09 BROWARD

October 17, 1995

BY ORDER OF THE COURT:

ORDERED that appellee's motion filed August 17, 1995, for rehearing/motion for rehearing en banc is hereby denied.

I hereby certify the foregoing is a true copy of the original court order.

MARILYN BEUTTENMULLER
CLERK

cc: R. Fred Lewis
Lawrence D. Bache
Frederick C. Sake
Roy Lloyd Taylor

IN THE CIRCUIT COURT OF THE SEVENTEENTH JUDICIAL CIRCUIT, IN AND FOR BROWARD COUNTY, FLORIDA

CASE NO. 92-13834 (09)

CHERYL M. PELOQUIN,

Plaintiff,

v.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Nebraska corporation, and UNIVERSITY DENTAL HEALTH CENTER, INC., a Florida corporation,

Defendants.

_____/

FINAL JUDGMENT AGAINST UNITED OF OMAHA LIFE INSURANCE COMPANY

THIS ACTION was tried before the Court after due notice to all parties. The Plaintiff and Defendant, UNITED OF OMAHA LIFE INSURANCE COMPANY, were present and both were represented by counsel. Defendant UNIVERSITY DENTAL HEALTH CENTER, INC. did not participate in this trial. Based upon the evidence and testimony pre-

sented, the Court finds in favor of the Plaintiff and against the Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY. It is, therefore,

ORDERED AND ADJUDGED as follows:

1. That the Plaintiff, CHERYL M. PELOQUIN, is covered under the governing group health policy, and does have and recover from the Defendant, UNITED OF OMAHA LIFE INSURANCE COMPANY, the principal sum of Twenty Eight Thousand Three Hundred Sixteen and 73/100 Dollars ($28,316.73) which shall bear interest at the rate of 12% per annum, for all of which let Execution issue forthwith.

2. That Plaintiff incurred Sixty Three Thousand Eight Hundred Ninety Five and 82/100 Dollars ($63,895.82) in medical expenses while covered under the governing group health policy, of which Thirty Five Thousand Five Hundred Seventy Nine and

09/100 Dollars ($35,579.09) has been paid. In the event that the Plaintiff is required to reimburse payment of the said Thirty Five Thousand Five Hundred Seventy Nine and 09/100 Dollars ($35,579.09), Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY shall be liable to furnish said sum to the Plaintiff or to make payment directly to the party or parties claiming reimbursement.

3. The Court retains jurisdiction to determine the recoverable attorney's fees and costs.

4. The Court retains jurisdiction of this cause as it relates to Plaintiff's claims against Defendant UNIVERSITY DENTAL HEALTH CENTER.

5. The Plaintiff and Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY stipulate, in the event an appeal is taken, that no appellate bond is required to

be posted by UNITED OF OMAHA LIFE INSURANCE COMPANY.

DONE AND ORDERED in Fort Lauderdale, Broward County, Florida, this _____ day of _____ 1993.

LAWRENCE L. KORDA JAN 3 1994
CIRCUIT COURT JUDGE

Copies furnished:
Lawrence D. Bache, Attorney for Plaintiff
Frederick C. Sake, Esq., Attorney for Defendant, UNIVERSITY,
Peter Restani, Esq., Attorney for Defendant, UNITED